

Scholar Practitioner Program Renewal Communicable Disease Screening Form

Student Name: _____ **Student Number:** _____

Date of Birth: _____

Student Authorization:

I have read and understand this information. I give my consent that the information on this form is accurate and true and may be shared as required with Nipissing University, Clinical Faculty, Administrative/Support Staff, and Placement Agencies.

Signature: _____ **Date:** _____

Dear Student,

The BScN Scholar Practitioner Program includes clinical placements as an essential component of the program. In order to protect yourself and the patients you will be interacting with, you must complete all required immunizations upon admission and annually as indicated. You may also be required to update any necessary immunizations during your enrollment in the program. It is your responsibility to carefully review the following instructions and ensure that you comply with all requirements.

1. General Instructions

- Please ensure your personal health care provider understands that the form must be completed as indicated. Every page and section **MUST** be filled out. Failure to comply may lead to repeat testing/immunization. Incomplete documents will be discarded.
- Agencies have reserved the right to refuse access to students who do not meet their clinical placement requirements. Agencies may also have additional requirements that are separate from the School of Nursing requirements.
- Documents that will be accepted as proof of immunization include the provincial Immunization Record, documentation signed by your health care provider (Registered Nurse, Registered Practical Nurse, Nurse Practitioner or Physician), or laboratory evidence (report). **All information from the aforementioned records must be recorded on your form and each page signed by a licensed healthcare provider (RPN, RN, NP or Physician in the section entitled Healthcare Provider Declaration.** Please ensure document is signed and designation of healthcare provider is included.
- Failure to submit a signed and duly completed Communicable Disease Screening Form to the School of Nursing will result in ineligibility to register for clinical courses.

The completed form must be saved as a PDF and uploaded to the Clearance Website. **Students must keep their original documents.** Questions regarding these instructions, the form and/or any other requirements, should be directed to the Clinical Clearance Office at 705-474-3450, ext. 4579.

Thank you,



Erica Skouras

Student Name: _____	Student Number: _____
Instructions	Immunization/Serologic Status
TUBERCULOSIS Tuberculin Skin Test (TST)	
<p>A current one-step TST dated no earlier than July 1 of the current year is required.</p> <p>Positive Results: Students with a history of a positive TST, are required to submit Appendix A, an Annual TB Surveillance letter in lieu of completing an annual TB Skin test.</p> <p>Future TSTs are not required but the annual TB Surveillance letter must be completed and submitted on an annual basis as part of your renewal clearance package.</p> <p style="text-align: center;"><i>*Please see Appendix A at the end of this document to include with your Communicable Disease Screening Form.</i></p> <p>Note: if indicated as moderate or high risk for active TB, a new chest x-ray will be required.</p>	<p><u>One Step Tuberculin Skin Test (TST)</u></p> <p>Date Given: (dd/mm/yy) _____</p> <p>Date Read: (dd/mm/yy) _____</p> <p style="text-align: right;">Result/Induration: _____ mm</p> <p style="text-align: right;">Interpretation +/-: _____</p> <p>Signature & Designation: _____</p> <p><u>Positive Result</u></p> <p><input type="checkbox"/> Student has a history of a positive TST. Date of positive TST: _____</p> <p>**Must include TB surveillance letter please see Appendix A</p> <p>**New chest x-ray <i>only</i> if indicated as moderate or high risk.</p>
<p><u>Licensed Healthcare Provider Declaration:</u> I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p>	

TETANUS/DIPHTHERIA	
Student Name: _____	Student Number: _____
Instructions	Immunization/Serologic Status
<p>Students must document vaccination for Tetanus & Diphtheria annually and be vaccinated every 10 years. To meet clearance requirements, immunity cannot expire before September 1 of the following clearance cycle.</p> <p>It is the <u>responsibility of the student</u> to ensure that these boosters remain up to date after admittance into the RPN to BScN Blended Program.</p>	<p>Primary vaccine or date of most recent booster received within the last 10 years:</p> <p>Vaccine Name: _____</p> <p>Date (dd/mm/yy) _____</p>
<p><u>Licensed Healthcare Provider Declaration:</u></p> <p>I confirm that the information provided on this form is correct:</p> <p>Name (please print): _____ Date: _____</p> <p>Signature: _____ Designation: _____</p>	

Appendix A - Tuberculosis (TB) Surveillance Letter*

Student Name: _____ Student Number: _____

As the student's primary health care provider, I _____ Please
Print Name

have deemed this student, whose Tuberculosis skin test is 'positive' (10mm or greater) to be absent of TB symptoms and at a (please check off appropriate box):

low risk for active TB.

moderate or high risk for active TB.

Note: if indicated as moderate or high risk for active TB, a new chest x-ray is required.

(Symptoms may include coughing that lasts longer than 2 weeks with green, yellow, or bloody sputum; weight loss, fatigue, fever, night sweats, chills, chest pain, shortness of breath and loss of appetite.)

Chest x-ray results required as per instructions from the Communicable Disease Screening Form (must attach copy of results if not previously submitted):

Result

Date

Physician/Nurse Practitioner Signature & Designation

Date

*Required for students with a current or past positive TB skin test result